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BASIC FACTS

DEBUNKING COMMON MYTHS ABOUT HEALTH REFORM

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The Affordable Care Act, signed into law in March 2010 and upheld by the Supreme Court in June 2012, includes major reforms of U.S. health insurance and efforts to improve health care. Here I briefly describe the key reforms and respond to frequently heard myths about the law.

What the Affordable Care Act Does

The Affordable Care Act (also known simply as Affordable Care) aims to make health insurance accessible and affordable for 30 to 35 million Americans who now lack coverage. Over the next ten years, about a trillion dollars will be allocated to expand Medicaid to more low-income people and to give low- and moderate-income families subsidies to buy affordable private insurance. To help people make informed insurance choices, each U.S. state has an insurance marketplace – called an "exchange" – where private insurers compete for new business by offering insurance plans for sale.

Affordable Care also includes new rules for insurance companies – to prevent them from denying coverage to people who become sick or have "preexisting conditions," and to allow young adults to remain on their parents' insurance until age 26.

Affordable Care improves Medicare coverage, by closing the "donut hole" that left some seniors with high out-of-pocket expenses for prescription drugs. Both Medicare and insurance policies for the non-elderly must now provide free screening tests, immunizations, and preventive care; the costs of these essential preventive services cannot be counted against any plan's deductibles. Further, as part of its focus on prevention and wellness, Affordable Care is raising the payment rates for primary care physicians who care for Medicare and Medicaid enrollees.

Other important provisions in Affordable Care encourage doctors and hospitals to try new ideas for improving quality and reducing costs in health care delivery.

When pollsters ask Americans about these individual provisions of health reform, large majorities respond in favor. But people are still divided about the Affordable Care Act as a whole – or "ObamaCare" as it sometimes called. The law remains unclear to many people, and quite a few subscribe to myths that are circulating about what the new law does or why it might not work. Let's look closely at some of these myths and get the facts straight.

Myth Number One: Expanded Coverage Sounds Good, but the United States Can't Afford It

Unlike many laws passed in Washington DC, Affordable Care includes specific measures to raise the revenues needed to fund the benefits it promises – to pay for the expansion of Medicaid and the new subsidies to make private insurance affordable.

To pay the tab, Affordable Care reduces over-payments to private insurance companies involved in Medicare, and charges fees to pharmaceutical companies, medical device manufacturers, and private insurance companies (all of whom will get new customers and reap added profits from newly insured people). Reform also trims future payments to hospitals serving large numbers of poor and uninsured people, because those providers are going to see reductions in free care they used to have to provide to uninsured Americans.

Because the new revenues and reduced costs included in Affordable Care more than offset the cost of new benefits, the nonpartisan Congressional Budget Office estimates that Affordable Care will reduce the federal budget deficit by $84 billion between 2012 and 2021, and by even more in the next decade. Conversely, repealing the law would increase the federal deficit.

Myth Number Two: Reform Imposes Government-Run Insurance on the States

Quite the opposite is true – the insurance marketplaces are where *private insurance companies can sell policies* to individuals and businesses. In consultation with businesses and consumer advocates, each state sets its own regulations governing the marketplaces – just as each state currently regulates small group and individual insurance markets. States determine the minimum benefits that all policies sold in the marketplaces must contain.

Myth Number Three: Small Employers Will be Fined if They Do Not Provide Insurance

Not true. Employers with fewer than 50 full-time employees are not required to sponsor or provide group insurance – and there is no penalty if they do not. Starting in 2015, firms with 50 or more employees that do not provide some coverage will be subject to a fee for some of their uninsured employees – but the fee is very small, much cheaper than buying insurance coverage.

Myth Number Four: The "Individual Mandate" Forces Every American to Obtain Insurance

People will always have a choice – there is no mandate. A small fraction of Americans – about two in every hundred – might have to decide whether to buy a private plan or pay a small tax penalty. This choice will NOT apply to people who have religious objections or who cannot afford insurance even after new subsidies are made available. And anyone with coverage through their place of work or Medicare or Medicaid will continue to have such insurance.

As the law makes health insurance affordable, it also emphasizes individual responsibility by making uninsured persons pay the true costs of their choice. Americans who ultimately choose not to obtain coverage will, by law, receive basic life-saving or stabilizing care if they are in emergency situations. However, chemotherapy treatments for cancer, drugs for chronic conditions, and primary care will not be provided to uninsured people unless they pay full-price for such care.

Once health insurance is affordable and people risk paying high costs if they choose to remain uninsured, experience and scholarly research suggest that almost everyone will want to obtain insurance coverage in one way or another – and that will help keep insurance prices and taxes down for all the rest of us.